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ABSTRACT

This study compared five popular instruments for assessing the quality of family child care: the Child Development Associate Competency Standards (CDA); the National Association for Family Day Care Assessment Profile (NAFDC); the Child Care Partnership of Dallas Family Day Care Home Observation Instrument; the Louise Child Care Scal for Evaluating Home Based Day Care; and the Harms-Clifford Family Day Care Rating Scale (FDCRS). The five instruments are compared in the following content areas: personal and social development and provider interaction; cognitive development; language development; creative development; physical development (small and large muscle); health; safety; nutrition; family support and interaction; and professionalism. Pros and cons are discussed for each instrument, and recommendations are made for accreditation, training, and public policy. (MM)

Assessing the Quality of Family Child Care
A Comparison of Five Instruments

Child Development Associate Credential (CDA)
National Association for Family Day Care Accreditation (NAFDC)
Dallas Family Day Home Observation Instrument
Louise Child Care Evaluation of Home Based Day Care
Harms-Clifford Family Day Care Rating Scale (FDCRS)

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Funded by Mervyn's

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Assessing the Quality of Family Child Care

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Additional copies may be ordered from The Family Child Care Project, Wheelock College, 200 The Riverway, Boston MA 02215; $5.00 for one, $8.50 for two.

See also companion handbook, *Training Programs for Family Child Care Providers — An Analysis of Ten Curricula.* (Same price and address.)

Assessing the Quality of Family Child Care
A Comparison of Five Instruments

Dedicated to family child care providers everywhere, who deserve to be recognized for the quality of care they offer, and to be assisted as they strive to improve the quality of their care.

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Overview

This handbook compares five popular instruments for assessing the quality of family child care:

- The Child Development Associate Competency Standards (CDA)
- The National Association for Family Day Care Assessment Profile (NAFDC)
- The Child Care Partnership of Dallas Family Day Care Home Observation Instrument
- The Louise Child Care Scale for Evaluating Home Based Day Care
- The Harms-Clifford Family Day Care Rating Scale (FDCRS)

Part 1 presents an overview of these five approaches, and describes their procedures and fees.

Part 2 presents grids analyzing the content of the five instruments for accreditation or research use.

Part 3 offers a tentative list of the pros and cons of each approach, based on this analysis and interviews with people who have extensive experience with one or more of the instruments.

Part 4 discusses issues raised and makes recommendations for accreditation, training, and public policy.

Parts 3 and 4 contain discussion and tentative conclusions which are offered in the spirit of inviting dialogue on the important basic questions of what is quality in family child care, and how can we best assess and support it.

Part 1. Introduction

Family child care is a major force shaping the development and well-being of our nation's young children. Also known as family day care or family day home care, it is the most popular form of child care in the United States, especially for children under age 3.

Because it is nearly invisible and often "underground," family child care has not received its share of attention — in professional development, research, or governmental support. This study reflects the concern that we have not sufficiently defined the components of quality in family child care. As a result, there is a lack of consensus about how to assess quality in provider research or accreditation.

Increasing numbers of researchers are recognizing the importance of studying family child care quality. Which instrument(s) should be used? Similarly, resource and referral agencies, communities, employers, and states want to recognize family child care providers who offer good quality care. Various means of accrediting or evaluating providers have been developed for this purpose. Five of the most popular ones are compared in this study. For convenience, the term "accreditation" is used to refer to credentialing and other forms of provider certification.

Several benefits of the accreditation process have been reported:

- it identifies standards of quality — standards which are higher than the minimal standards of state regulations;
- it gives professional recognition to deserving providers, which raises their self-esteem;
- it creates incentives for providers to improve their business and child development practices;
- it helps parents look for quality child care; and
- it draws providers into training and continuing education.

Other positive consequences, by implication, include:

- it encourages providers to identify themselves as professionals, perhaps bringing them into a network of professional/peers who offer support and technical assistance;
- it increases the likelihood of a provider's success and builds commitment to the job, which in turn reduce the high turnover in this occupation and thereby increase supply and retention;
- it increases the pay-off of dollars spent for training and accreditation by keeping providers in the field longer; and
- it encourages the provider community to come together and support each other in upgrading quality.

Clearly accreditation is an effective means of increasing the quality of family child care, and should be widely supported. But which of the many accreditation or credentialing instruments should be used? Following is a comparison of the five instruments.

Five Approaches to Assessing Quality

The CDA Credential

Overview. The CDA (Child Development Associate) Credential is presented first, because it has had an acknowledged influence on the other instruments in this study. The Council for Early Childhood Professional Recognition, in Washington, D.C., administers the assessment and credentialing of family child care providers throughout the United States. This office receives grant funds from the federal government and was founded by the National Association for the Education of Young Children. Each provider works with a local team including an Advisor and a Parent/Community Representative (who are selected by the provider according to a set of criteria), and a representative from CDA. The local team decides whether or not to recommend that the provider be awarded the Credential.

The CDA *Assessment System and Competency Standards* presents the rationale and developmental context for each of 13 functional areas of competency, giving information about children's unique characteristics and needs. Samples of caregiver behaviors that demonstrate competency in each area are listed, with specific examples for four developmental levels: young infant (birth-9 months), mobile infant (6-18 months), toddler (16-36 months), and preschool children (3-5 years).

The Advisor works with the provider over a period of at least 12 weeks, making three or more visits with at least three weeks between visits. The Advisor helps the provider identify areas which need improvement and ways improvement could be accomplished. The provider assembles a portfolio with examples of her work that demonstrate competency in each area. The assessment team members visit the home to evaluate the provider on the compentency criteria.

Other information needed for the portfolio include the provider's autobiographical statement and program goals and description. The Parent/Community Rep (who is not a parent in the program) surveys the enrolled parents, makes an observation visit, and writes up the observation. When all the steps have been completed, a representative from CDA meets with the team, and observes and interviews the provider about her/his knowledge and work in each of the competency areas.

There is no checklist of specific behaviors that must be demonstrated. Instead, each competency is accompanied by many examples of possible ways a provider could demonstrate it. Some of the statements are general and difficult to verify objectively, such as the provider "understands and respects the individual eating and sleeping needs of healthy infants." For this reason, the CDA assessment has been criticized for being prone to influence by the evaluators' knowledge level and biases. On the other hand, many of the criteria are clearly defined and specific, and it has the advantage of covering many of the important but elusive factors that are difficult to assess with a behavioral checklist.

The experts interviewed for this study were unanimously of the opinion that the CDA works best in conjunction with training that helps providers interpret and apply the criteria.

Eligibility. The provider must:

- be at least 18 years old;
- care for at least 2 unrelated children ages 5 or under;
- have at least 10 months experience in family child care, and at least 640 hours of experience with children ages 5 and under;
- meet minimum state/local regulatory requirements;
- be able to speak, read, and write well enough to carry out the credentialing procedures; and
- have had at least 3 relevant educational experiences of some kind, including workshops, conferences, or courses (2 of these must be in early childhood education/child development).

Procedures

- Provider chooses local team of Advisor and Parent/Community Rep; they complete application.
- Local team assembles information including provider portfolio, Advisor observations, and Parent/Community Rep observation and questionnaires from enrolled parents. Team completes assessment. (May take from 12 weeks to a year or more.)
- National CDA Rep observes and interviews provider and meets with team. Group decides whether to recommend credential or further training.
- National office reviews proceedings, awards credential.
- Credential must be renewed in 3 years. Renewals good for 5 years.

Fees. $325. Scholarships available for very low-income providers (may raise income eligibility level in 1991).

Upcoming Changes in CDA

Beginning in 1992, the CDA will modify its procedures (these will be effective for applications received after September 1, 1991). At that time, there will be two ways a provider can get a CDA:

1. *Direct Assessment.* This approach will remain similar to the current procedures, as described above, but there will be an exam

added as part of the process. New eligibility rules will require that providers have High School diplomas or GEDs, 480 hours of experience with children ages 5 and under, and 120 hours of formal training. Providers will be able to put together their own training from programs of their choice (these must be organized, ongoing programs, not conferences or one-time workshops). They must include at least 10 hours in each of the competency areas and 2 new areas: Observing and Recording Child Development, and Introduction to the Profession.

2. *The Professional Preparation Program.* This new CDA option will be centered around 1-year training programs for center-based and home-based care combined. Students will begin by working in child care settings, meeting weekly with their Advisors, and completing assignments. In the middle phase, they will participate in 120 hours of college seminars. In the final phase, students will be observed working in a child care home, and meet with a CDA representative for an oral assessment.

Colleges and other post-secondary training institutions will apply to the Council to participate.

NAFDC Accreditation

Overview. This Accreditation is administered to providers across the country by the National Association for Family Day Care (NAFDC), in Washington, D.C. NAFDC is the national professional organization of family child care providers.

The *Assessment Profile for Family Day Care* is a structured observation guide that assesses seven dimensions of child care, each with general standards and concrete, observable criteria. Some of the standards list additional criteria for infants. The approach of the instrument differs from the CDA by limiting discussion of general principles and rationale, and instead focusing on clearly defined, specific behaviors.

Each provider selects a Parent Validator according to specified criteria, and is assigned a validator from NAFDC. All items on the assessment must be scored by both validators and the provider. The validators are instructed to interview the provider if a behavior is not observed. To gain accreditation, the provider must score an average of at least 85% overall, and no less than 75% on any dimension by any observer. A determination to award accreditation is based on this score, the provider's written report, and a parent survey.

The experts interviewed agreed that NAFDC accreditation can be used without a training program but most providers need some form of support to get through the process. Local provider associations may be the ideal group to offer support.

Eligibility. The provider must:
- have been actively caring for children in her own home for at least 18 months; and
- meet voluntary and mandatory state regulatory requirements.

Procedures
- Provider chooses a Parent Validator who does not currently have a child in provider's care.
- Provider may choose a colleague or resource person for help and support. Some programs assign a family child care specialist to assist provider.
- Provider completes self-evaluation, using Assessment Profile
- Enrolled parents complete survey.
- Parent and NAFDC Validators visit home for at least 6 hours on different days, and complete Assessment Profile.
- Provider writes final report based on summary of Assessment Profiles. (Process must be accomplished within 60 days of receiving materials).
- Valid for 3 years, updated annually.

Fees. $75 with application, $75 with completed materials.

Dallas Accreditation

Overview. The Child Care Partnership of Dallas (CCP), Texas, uses its *Family Day Home Observation Instrument* to accredit providers in conjunction with a 36-hour training program and home visits.

The instrument consists of a checklist of criteria divided into 5 areas, derived from the CDA's 13 functional areas. These criteria tend to be broader in scope than NAFDC's, but worded in language that is more objective and observable than CDA's. Each criterion must be scored, unless it is logically impossible (such as criteria about infant care when there are no infants present). Negative scores are entered for non-observed behavior. The scoring system is weighted to require varying levels of compliance. Safety, health, and nutrition requiring 90%, child development areas requiring 80%, and business practices, parent/family, and learning environment requiring only 50%.

A central feature of Dallas' approach is the training, which is geared to the accreditation criteria.

Eligibility The provider must:
- be registered with the Texas Department of Human Services, or in the process of registering.

Procedures

- Provider completes at least 24 hours of the CCP's 36-hour training.
- Provider receives at least one home visit from trainer and one from CCP staff member.
- CCPs Early Childhood Commission reviews materials and makes accreditation decision.
- Must be renewed annually.

Fees. $50 for training, $30 for validation visit, $10 for Partnership Subscription (partial scholarships available).

Louise Child Care's Home Based Day Care Evaluation

Overview. The *Evaluation of Home Based Day Care* (1988) is a checklist of specific criteria to assess providers' behavior. It was designed for self-evaluation or for an observer to assess the level of quality of care — it was not intended to be used for accreditation. It follows the basic CDA functional areas and can be used in conjunction with CDA training. It designates three levels of quality: Basic Care (minimal, custodial care), Intuitively Good Care (average care, "somewhat analogous to the concerned care the child would receive in his own home") and Informed Care (sophisticated care resulting from special training). Only the third level approaches the quality level required by the other accreditation approaches (see discussion in Part 4).

The evaluation is intentionally brief, and focuses on the quality of provider-child interactions. It is assumed that if providers are responsive to children and sensitive to their cues, the rest will fall into place. The scale was designed to be used with providers who have met the health, safety, and record-keeping requirements of Pennsylvania state licensing. In other cases the authors recommend using an additional checklist to assess these areas. The entire evaluation will be revised in 1991 to be relevant in other states.

An evaluator rates the provider on each criterion, subtracts the negative scores from a perfect score to get the final score, which is then designated as Basic, Intuitive, or Informed Care. Note that in this system, providers are not penalized when criteria are not observed.

The Louise instrument is the briefest of those in this study. Consequently it is the least time consuming to administer, but it is not as thorough as the other assessments. Its Intuitive Level is probably the easiest of the various assessments for a provider to "pass" successfully.

Procedure. Evaluator visits provider's home, scores items, and designates level based on total score.

The Harms-Clifford Family Day Care Rating Scale (FDCRS)

The Harms-Clifford Family Day Care Rating Scale (FDCRS) was adapted from the Early Childhood Environment Rating Scale, a center evaluation scale by the same authors. It is designed as an observation tool to assess the family child care home and provider according to six categories.

The categories encompass 32 items, each of which is scored on a scale of 1 through 7. Each level has specific criteria attached to it, which the rater must observe in order to make a rating on that item. The ratings are assigned general values so that 1 indicates Inadequate care, 3 indicates Minimal Care, 5 indicates Good Care, and 7 indicates Excellent Care.

This instrument emphasizes classic early childhood learning activities, the environment and materials, schedules and basic care routines. There are supplementary items for assessing a provider who cares for children with special needs, and a few additional items for programs with children under age two years of age. Media and print training materials are also available.

The instrument can be used by researchers, by providers for self-evaluation, or by agencies.

Procedure. The evaluator rates the provider and home environment on each item, based on specific descriptions. The authors suggest that observers need to spend 2 hours or more at the home. Items that are not observed should be assessed through questions phrased "so that they do not give the answers away." (p.4) Level 1 lists negative items, any one of which requires an automatic Inadequate score. A mid-point rating is given when all lower items and half or more of the next higher-level items are observed.

Part 2. Comparison of the Content of the Five Instruments

Although the content in each of the five instruments is arranged differently, reflecting their different priorities, there is actually a great deal of overlap. The following grids attempt to describe the content of each instrument across ten general categories: Personal and Social Development and Provider Interaction; Cognitive Development; Language Development; Creative Development; Physical Development; Health; Safety; Nutrition; Family Support and Interaction; and Professionalism. Only specific criteria have been included in this grid; more general discussions and background information have been omitted.

	CDA	NAFDC
Personal/ Social Development and Provider Interaction	This instrument offers a uniquely comprehensive assessment of the quality of the provider's interactions with the children. It assumes that this quality will be manifested in all areas: health, safety, nutrition, and in supporting the children's development of cognitive, language and social skills. This instrument outlines specific practices to support personal and social growth according to each child's level of development and cultural background in three areas: Self, Social, and Guidance. Self: Provider has affectionate and appropriate physical contact with each child daily; offers choices in activities, materials, and foods; helps children practice skills when eating, dressing, cleaning up, using toys and equipment; gives one-to-one attention; delights in each child's success; helps children recognize and accept their feelings and express them in culturally appropriate ways, and provides a model by naming own feelings. For infants: holds infants close and responds appropriately to infant's cry by comforting or feeding. For mobile infants: recognizes difficulties with separation and fear of new adults; talks to child about his/her family. For toddlers: supports child's developin g awareness of self as a member of a family or social/ethnic group by talking about families, using photos, books, pictures. For preschool children: the provider comments positively about their performance and differences and similarities; talks with children about ideas; helps children appreciate racial, ethnic, and ability differences; discusses "good" and "bad" touching as a way of preventing sexual abuse. Social: Provider serves as a social model by building a positive relationship with each child and parent; learns about children's stages of social development and has realistic expectations for behavior; helps children to respect the rights and possessions of others: encourages children to help one another and make friends; helps children become aware of feelings by talking about them; responds to social gestures and noises of infants by elaborating and playing social games: provides infants with opportunities to observe older children and adults; engages in social play that supports social skills (turntaking with a ball, conversation at meals); encourages toddlers to use words to resolve conflicts; involves older children in helping younger ones; uses stories, pictures, and other materials to deal with issues like sharing, separation, and negative behavior. Guidance: Provider knows a variety of positive guidance methods (listening, reinforcement, redirection); avoids negative methods such as spanking, threatening, shouting. Establishes guidelines for behavior that encourage self-control and are simple and consistent; addresses the problem behavior or situation rather than labeling the child; works with parents to address disciplinary problems and refers them to resources as appropriate; says "no" to mobile infants for guidance or safety and gives a simple explanation; explains to toddlers the reasons for limits; involves older children in setting limits.	This instrument assesses the quality of the provider's interactions in five areas which emphasize the provider's role in facilitating and supporting the child's personal/social develoepement. Provider is warm and nurturing with the children: uses affection with physical gestures (smiles, hugs, pats, holds); initiates positive verbal exchanges (praise, acknowlegement, cooing to infants); demonstrates a sense of humor (engages children in laughter, playful games); shares personal feelings about the day to children; spends one-to-one time with each child (holding, rocking, looking at a book). Provider is attentive and responsive: infant's babbles and child's ideas and feelings are acknowledged with a verbal response or physical gesture; child's spontaneous ideas and interests are extended through discussion or activities; allows children to make choices; attends to infant who does not quiet within 20 minutes at nap time, and does not leave infant in crib after nap. Provider assists infants and children in cooperative activities: rolling a ball, taking turns on a slide, pulling each other in a wagon; provider places nonmobile infants so that they can observe and interact with older children; helps infant and children make choices when taking a toy away. Provider manages child's behavior positively: clearly states limits and behavioral consequences; intervenes to prevent or redirect undesirable behavior; avoids yelling, criticizing, scolding, threatening; avoids negative physical actions (smacking, yanking); removes a child who is persistently disruptive or harmful for 3 minutes or less. Children appear to be happy and involved in activities: children are smiling and laughing freely; children are handling materials; children are cooperating and sharing; children are babbling or talking; children are setting up or cleaning up activities, making their own decisions. Omits multicultural and nonsexist activities and materials; encouraging children to give and ask for help; helping children to understand own and others' needs and rights.

(continued)

	Dallas	Louise	FDCRS
Personal/ Social Development and Provider Interaction (continued)	This measure emphasizes the provider's responsiveness to "help each child develop a sense of independence... communicate and get along with others...and encourage feelings of empathy and mutual respect among children and adults." Provider uses affectionate physical contact (holds infants closely, hugs and cuddles older children); uses children's names; listens and responds to children's concerns; gives one-to-one attention; comments directly and positively about children's ideas and performance; comforts distressed child. Provider encourages independence when child is ready by providing opportunities for dressing self, feeding self, washing own hands, choosing own toys, cleaning up; offering choices; allowing older children to have input in rule-making. Children have space for personal belongings. Provides a relaxed, social mealtime and sits with children when possible. Provider uses materials and books, musical activities, and celebrations that are meaningful to young children and are representative of the cultural customs of all the children in the home. Encourages prosocial behavior (cooperating, helping, taking turns) by modeling the behavior, encouraging children to ask for and give help. Provider helps children deal with anger, sadness, and frustration by talking through conflicts. Omits non-sexist materials and activities; limited in assessment of how provider manages and guides behavior.	Emphasizes child guidance and positive discipline. Level One: Provider avoids the use of shaming to control behavior. Level Two: Supports self and social development; uses words of praise more than criticism; smiles or has a neutral expression more than an expression of dislike or disapproval; shows no obvious preference among the children; avoids comparing children negatively; holds and cuddles infants frequently; comforts a distressed child, does not chide. Plans time for individual attention. Level Three: Can cope with child's aggression; tries to interpret the causes of anger and gets child to substitute words for aggressive acting out. Helps children recognize own/ other's rights; teasing, shaming, swearing, name-calling are controlled; protects the rights of all the children to use the equipment; provides child with personal space and space "to get away from it all" where possible. Expresses understanding of emotions. Tolerates thumb sucking, bottles, transitional objects, other dependency. Can cope with the need for independence and achievement striving; promotes self-feeding (finger food for infants, manageable utensils, pre-cut food for toddlers), self-care (washing hands, getting dressed), serving, cleaning up; allows real choices; values and praises child's achievement; encourages mastery of new skills. Omits multicultural and non-sexist materials and activities; encouraging children to help one another and make friends, and to ask for help.	This instrument emphasizes the importance of provider's interactions with each child at greeting and departing; interacting with children frequently, not leaving infants or toddlers alone in cribs or isolated; providing a space in which children can be alone or where provider can interact one-to-one with children. It assesses nap and rest times in terms of adequate space; supervision; helping children to relax; appropriate nap schedules to meet the needs of non-nappers, infants, and early risers. Inadequate: Provider and children seem tense, angry, children cry often; physical contact used mainly for control; either discipline is so strict that children are punished often, or so lax there is no order or control; severe discipline (shouting, spanking) used as control. Limited cultural awareness: toys and pictures displayed of one race (e.g., dolls, books); boys and girls limited to traditional roles (e.g., girls toward housekeeping). Minimal: Physical contact mainly routine, little affection; provider does not often smile, talk, or listen to children; provider never uses physical punishment; maintains enough control to prevent children from hurting one another. Some cultural awareness: dolls and books from at least two racial groups; boys and girls not limited to traditional roles in choice of play activities. Good*: Provider uses physical contact to show affection to all children (hugging, holding); provider and children seem relaxed, voices cheerful, a lot of smiling; alternatives to physical punishment used effectively (time out, praise for good behavior), age and ability of children considered when rules are made; reasons for rules explained. Equipment promotes self-help (steps near sink, child-sized toilet seat). Self-help in grooming (bibs and smocks available); care given to children's appearance. Infants held when given bottles, no bottle props; provider makes meals a pleasant, social time. Cultural awareness: many examples of racial variety in dolls, pictures and books; holidays and cultural customs of all children in group included; boys and girls encouraged to choose non-traditional activities; people of all ages represented in pictures and books. Excellent*: Provider and children show respect and kindness for one another; provider thinks ahead and handles minor discipline problems before they become major; helps children to find solutions through discussion. Provider plans the use of multicultural, multiracial and non-sexist materials. Self-help skills encouraged (finger-feeding, children help set table, help prepare food and serve). Omits encouraging children to give and ask for help; helping children to understand own and others' needs and rights; acknowledging children's feelings. Few criteria pertaining to infants and toddlers. * Note: Remember that good care requires that all minimal stardards are met as well; excellent care requires that all minimal and good standards are met as well.

	CDA	NAFDC	Dallas	Louise	FDCRS
Cognitive Development	Emphasis on cognitive development through play; provider joins children's play as a partner and facilitator; adjusts routines and schedules for extended concentrated play; gives children opportunities to figure out cause and effect; encourages infants to manipulate and inspect a variety of objects. Emphasis on cognitive development through daily activities; uses the home environment, cooking, gardening, repairs; solving problems that arise in daily activities; field trips; encourages questions, active learning rather than passive listening; encourages children to talk about ideas; helps children understand concepts such as space, time, shape and quantity through many different activities. Limits TV watching time and programs; talks to children about what they see and hear. Emphasis on different activities and approaches to use with different ages according to developmental stages. Omits accessibility of toys and materials, rotation of toys and materials; does not suggest specific materials for different areas of development.	Emphasis on a variety of materials to encourage independent exploration; small muscle/manipulatives (puzzles, legos); music materials (tape cassette, musical toys); language materials (books, magnetic letters); clean-up materials (broom and dust-pan, sponge); art materials (crayons and paper, play dough); drama/self-awareness materials (dress-up, puppets, dolls, cars); all available without adult assistance. Emphasis on quality of children's play and provider interactions; provider directly involved with children's play and learning activities for at least one hour; limits TV to child-oriented programs no more than 2 hours a day; provider looks at and/or reads books with children; rotates toys and materials for variety; provider demonstrates use of a toy or material; provider asks questions that require reasoning. Routine tasks are used as learning opportunities; children have the opportunity to manipulate and experiment with concrete materials that illustrate or teach abstract concepts (such as shape, size, weight, quantity, color). Criteria for cognitive development are integrated into sections on indoor play environment and provider's interactions, but there is a clear emphasis on facilitating learning through activities, materials, and provider's interactions. Few criteria pertaining to infants and toddlers.	Emphasis on cognitive development in a learning environment; provider uses routines/household jobs as learning opportunities (chores, preparing food, talking informally to children, clean-up); has a variety of developmentally appropriate materials available for different ages (rattles, push/pull toys, puzzles, picture books, blocks, games, arts materials); materials accessible to children for self-selection; adds to and changes materials regularly. Emphasis on a flexible schedule; provider has simple, consistent routines for nap time, meal time, play time; allows sufficient time for children to play, complete tasks; plans learning experiences around everyday community resources (grocery store, park, library). Emphasis on provider interactions; limits TV/VCR time and chooses programs appropriate for young children; provides a balance of child-initiated and caregiver-initiated activities; uses materials and books, musical activities, and celebrations that are meaningful to young children. Importance of children's learning through play, routines, and caregiver interactions clearly defined; criteria objectively stated. Omits development of math concepts.	Provider allows children to follow through on their play ideas; allows initiative in play. Emphasis on cognitive development through daily activities; sets aside portion of the day for learning experiences; exploits natural learning experiences presented in the home; uses field trips; restricts the use of TV; attempts to plan schedule for individual attention. Emphasis on provider interactions; shows appreciation; reads to children; assists with use of materials; uses elaborative mode of conversation; responds to infants verbalizations; encourages group conversation. Minimal emphasis on developmentally differentiated activities for infants and older children. Omits clear criteria and specific materials for encouraging learning experiences; omits development of math concepts. (See Part 4. for an explanation about why the authors omitted some of these areas.)	Inadequate: No appropriate materials, or inappropriate teaching of school skills to children who are too young or not interested; TV is always on and/or with adult programming. Minimal: Daily activities used to help children learn concepts (commercial or homemade toys to learn colors, sizes, shapes, numbers and letters, puzzles; activities like nature, science, cooking). Some eye-hand materials. TV used as a babysitter, not on more than 2 hours a day; not limited to programs considered good for children. Good: Variety of games and materials; asks questions to encourage reasoning; at least one nature/science/cooking activity each week; a variety of eye-hand materials; space provided to play with materials. Provider limits use of TV to programs and games regarded as good for children, activities provided as an alternative when TV is on. Excellent: Provider works with every child at least 1x/week on an appropriate concept development game (shape sorting boxes, puzzles, numbers); encourages reasoning throughout the day by pointing out sequence and results; materials rotated to maintain interest; materials organized to encourage self-help; provider helps children develop skills (cutting, puzzles, etc.). Provider uses TV as an educational experience; joins children in viewing, asks questions, adds information, or chooses not to use TV at all. Omits facilitating and extending children's spontaneous play. Emphasizes relatively formal learning activities.

	CDA	NAFDC	Dallas	Louise	FDCRS
Language Development	Emphasis on provider facilitating language development; provider acknowledges infant's babbling and/or body signs and child's feelings with gestures or verbal response; provider listens without interruption; children's ideas are extended through discussion; provider uses grammatically correct language; provider extends and elaborates infant vocalizations and child's language. Writes toddlers' "stories" and labels their drawings to relate spoken and printed words; looks at books and magazines with children; uses a variety of songs, stories, books and games for language development; encourages children to talk about their experiences; talks to infants about what they see and what is happening. Shares children's language achievements with parents; talks to parents about the meaning of infant's beginning communication; recognizes possible impairments or delays that affect hearing and speech and helps families find resources. Emphasis on bilingual development; helps children associate word meanings in both languages with familiar objects and experiences; supports parents in teaching language of their culture and learning second language. Criteria are objective, clearly defined, and capture how a provider can facilitate the acquisition and development of language. Criteria are sensitive to needs of different age groups.	Provider initiates positive verbal exchanges such as praise, acknowledgement, conversation, cooing to infants; engages children through verbal exchanges; shares personal feelings and/or experiences as related to the activities and experiences of the day, spends quiet one-to-one time with each child. At least 3 language materials are reachable by the children without adult assistance (books, play telephone, tapes). Gives clear, understandable directions, reads/looks at books with children, asks questions that require remembering specific facts and problem solving, uses grammatically correct language. Negative verbalizations are avoided (yelling, criticizing, scolding, threatening, sarcasm). Provider listens to infant vocalizations and child speech without interruption, elaborates upon infant vocalizations and child's language, extends child's vocabulary (naming objects for infants, clarifying meanings for older children). Provider talks with a child at the child's eye level, acknowledges infants babbles, extends child's ideas and interests through discussion, is involved with children at meal times, addresses individual children at arrival and departure. Provider is directly involved with children's play and learning activities for at least 1 hour per day. Criteria are objective, clearly defined and capture how a provider can facilitate the acquisition and development of language. Omits bilingual children's language development; omits writing children's words.	Emphasis on provider facilitating language development; supporting the acquisition of verbal and non-verbal means of communicating thoughts, feelings, and needs; has frequent, informal conversations during routines (meals, diapering/toileting, arrival/departure); adds to and elaborates on child's language; helps children talk about their experiences (helps label feelings; objects, people). Emphasis on specific materials available to help children develop language (pictures, books, puppets, nursery rhymes, finger plays, records, tapes, singing songs, dramatic play props); provider reads to children of all ages; talks, sings, and plays with infants and toddlers (e.g. peek-a-boo); recognizes possible impairments or delays that affect learning and speech and obtains special materials and equipment for chilren with learning diabilities. Emphasis on reasoning; helps children use words to solve problems; encourages children to ask questions. Encourages bilingual children to learn both languages; sees that bilingual children learn "survival words" (e.g. "I'm hungry", "I need to go to the bathroom"). Criteria are objective, clearly defined and capture how a provider can facilitate the acquisition and development of language. Omits provider's acknowledgement of infant babbling; omits writing children's words.	Some emphasis on provider's verbal interactions; encourages conversation among the group; often speaks to baby; responds to baby's verbalizations with her own; reads to children; uses an elaborative mode of conversation with many descriptives. The importance of provider's positive responses, especially around discipline and toilet training are noted in Social/Personal Development and Physical Development, respectively. This instrument does not include many items related to language; omits bilingual children's language development; provider's acknowledgement of children's feelings; writing children's words; materials for language development.	Inadequate: Little or no talking; talking used to control children's behavior and manage routines. Minimal: Some games and records present; provider names objects; reads or uses materials at least 3x/week; few materials available for language development (puppets, dramatic play props, records, dolls, toy phone). Good: Provider responds to infants' sounds; sings to child, imitates child's sounds; maintains eye contact while talking to child; much social talking between provider and children; children's talk encouraged (provider listens, asks questions); provider adds to children's ideas; many materials for language development accessible for independent use. At least 12 books for infants/toddlers and/or at least 20 for children over 2; provider names objects and talks about pictures; several picture games available; at least one planned activity daily (reading, saying nursery rhymes). Excellent: Provider talks to infants and toddlers during routines about child's activities; repeats what toddlers say, elaborating when appropriate; encourages toddlers to use words; checks out materials from library once a month; works on improving language all day (gives clear directions, uses words exactly, points out items of interest such as reading food labels and road signs); provides a variety of activities daily to encourage talking in each age group (infants/toddlers name objects, older children dictate stories). Criteria are objective, clearly defined and capture the acquisition and development of language. Omits bilingual children's language development.

	CDA	NAFDC	Dallas	Louise	FDCRS
Creative Development	Provider "supports the development of children's creative impulses by respecting creative play and by providing a wide variety of activities and materials that encourage spontaneous expression and expand children's imagination." Provider does not encourage uniformity; allows for spontaneous and extended play; includes a variety of music, art, literature, dance, role playing, celebrations and other creative activities from the children's cultures; participates in make-believe games with children; regularly provides unstructured materials (blocks, paint, clay, musical instruments); provides "messy" activities (sand and water play, finger painting); is alert to infants' initiatives to play; introduces new materials (fabrics, empty containers, objects that make different noises); provides male and female dress-up clothes for toddlers; encourages storytelling in older children. Criteria are thorough and well-defined, with an emphasis on the child's individuality and level of development.	At least three types of art materials and three types of drama/self awareness materials are reachable by children without adult assistance. This instrument does not specifically evaluate the provider's support and enhancement of the children's creative development. Omits the provider's interactions with the children in pretend play; omits sand play and minimizes water play; does not address the creative needs of older children vs. toddlers and infants.	"Creative play is supported by the... provider allowing time, space and materials for the children to create their own works." Plans daily, age-appropriate creative activities for the children: water/sand/mud, finger paint, playdough/clay, cutting/pasting/gluing; crayons and paper available all the time. Provides dramatic play material to encourage pretend play: adult clothing for dress-up, play dishes, pots and pans, dolls and doll accessories, blocks. Provides musical experiences for all age groups: musical toys for infants, musical instruments, records and tapes, movement and singing. Omits the provider's interactions with the children in pretend play; does not address the creative needs of older children vs. toddlers and infants.	This instrument does not evaluate the provider's support and enhancement of the children's creative development, or materials offered for creative play.	Good: Crayons and paper or other drawing materials accessible daily for free expression, coloring books not considered drawing material; emphasis on different materials for toddlers and preschoolers; art materials needing supervision at least 3x/week (cutting, pasting, painting); very few projects have children copy an example; musical experiences regularly available to children 3x/week (provider sings with children); emphasis on materials for all ages; sand or water play at least 1x/week with a variety of toys (cups, funnels, trucks, spoons); variety of dramatic play materials with accessories available daily; emphasis on a variety of props for role playing; variety of blocks and accessories with space set aside (small people, toy trucks and animals). Excellent: At least 2 different activities offered preschoolers daily and one 3-dimensional activity (carpentry, modeling); space and time for movement and music daily; variety of dance props and musical instruments accessible for independent use; sand and water at least 3x/week; dramatic play materials well-organized for independent use; some child-sized play furniture; blocks and accessories well-organized for independent use (labeled boxes or labeled, open shelves). Emphasis on display of child's artwork at child's eye level; displays change to match children's activities and interests. This instrument does not emphasize the provider's role in supporting creative development beyond her provision of materi als and activities. Omits the provider's interactions with the children in pretend play; does not address the creative needs of older children vs. toddlers and infants.

	CDA	NAFDC	Dallas	Louise	FDCRS
Physical Development **Small Muscle**	Provides appropriate activities and materials to help infants grasp, pull, push; encourages manipulation of objects and tools (strings to pull toys, pail and shovel); encourages the development of eye-hand coordination (shape box, self-feeding). For toddlers: play dough, puzzles, fingerplays. For preschoolers: cutting, painting, drawing, buttoning, zipping; supports self-help skills such as tying shoes. Provides opportunities for children to develop their senses by helping them to notice colors, odors, sounds, feeling and touching a variety of objects; tasting different foods. Adapts program to meet needs of children with handicaps or developmental delays, taking into account the importance of physical development to self-concept and social devopment.	Provides at least 3 different types of small muscle/manipulative materials that are reachable by the children without adult assistance, and children have opportunities for small muscle activities (puzzles, drawing, reading, legos, squeeze toys, large snap beads). Children have opportunities to manipulate and experiment with concrete materials that demonstrate abstract concepts (shape, size, weight, quantity, color).	Provides a variety of opportunities to stimulate the development of small muscle skills and eye-hand coordination. For infants: small objects for grasping, mouthing. For toddlers: finger games, play dough; for preschoolers: cutting, painting, drawing, buttoning/zippers. For school-age children: sewing, arts & crafts, cooking, puzzles. Provides opportunities for children to develop their senses by helping them to notice colors, odors, sounds, feeling and touching a variety of objects; tasting different foods.	Provides crib mobiles, cuddly toys, objects to manipulate for infants; provides manageable eating utensils. Limited assessment of small muscle and eye-hand development.	Inadequate: No safe outdoor or indoor space used for active physical play; no indoor crawling space for infants and toddlers; no materials, or they are in poor repair; infants and toddlers confined for more than 30 minutes. Minimal: Safe outdoor physical play provided at least 3x/week; clean, safe indoor space provided for infants and toddlers; some materials, all in good repair. Adequate indoor space for crawling and playing; space clear of breakables. Good: Outdoor space used 1-3 hours daily; physical activity provided indoors in bad weather; materials stimulate a variety of large muscle skills (for infants: push-pull toys, crib gym, walkers. For toddlers and preschoolers: wagon, tricycle, scooter, balls, climbing objects). Two or more play areas defined indoors; adequate storage space. Small muscle: a variety of eye-hand materials accessible daily — at least 8 for each age group (infants: rattles, nested measuring cups; toddlers: peg boards, small building toys; preschoolers. crayons, scissors, puzzles). Excellent: Many materials for each age group; materials provided for imaginative play (moveable boards and crates); new challenge added every week through planned activity (tunnel, bean bag games, tumbling on mat). Arrangements of materials indoors made to promote independent use by children (labeled storage boxes or shelves). Eye-hand materials rotated; organized to encourage self-help; provider assists children to develop small muscle skills. Omits children's special physical needs; omits sensory development.
Large Muscle	Provider plans and participates daily in appropriate large-muscle activities (playing ball, jumping, climbing); provides activities from children's cultures (dances, music, active games); never forces children who are fearful; provides infants freedom to move and explore in a variety of safe spaces (bare floor, carpet, mattress); provides mobile infants with safe opportunities for crawling, walking, climbing. For toddlers: introduces ride-on toys, boxes for climbing. For preschoolers: plays physical games such as tag or jump rope. Makes large muscle provisions indoors when weather prevents outdoor play. Emphasis on sharing a child's pleasure at physical activities and mastery of physical skills.	Provider engages children in large muscle exercises. Children have opportunities for large muscle activities (such as dance, tumbling, exercise). Children have opportunities for outdoor activities daily. At least 3 different types of large muscle equipment are available for infants (rocking horse, balls, pull toys, slide). Omits provisions for infants to explore; omits children's special physical needs; omits sensory development.	Plans for outdoor play daily. Provides a variety of opportunities to stimulate large muscle skills; for infants: rolling over, sitting up, pulling up on sturdy furniture; for toddlers: walking, riding toys, climbing; for preschoolers: throwing balls, running, balancing; for school age: sports, jump rope, climbing. Allows infants freedom to move and explore in a variety of safe spaces (carpets, mattresses, bare floors). Adapts the program to meet the needs of children with handicaps.	Allows regular outdoor play; there is adequate space outdoors; provides legitimate opportunities for active large muscle play; provides opportunities for appropriate motor activities for infants. Omits children's special physical needs; omits sensory development.	

	CDA	NAFDC	Dallas	Louise	FDCRS
Health	Emphasis on healthy environment; adequate ventilation, lighting, and room temperature; clean play areas and materials; maintaining health records for each child; emergency numbers; communication with parents; knowledge of health resources in the community. Emphasis on personal hygiene of provider and children; sanitizing toys; washing hands after toileting, nose blowing, before food preperation or eating; sanitary diaper changing and disposal. Emphasis on recognition of unusual physical or behavioral symptoms; isolating sick children; contacting relatives; knows First-Aid procedures; recognition of symptoms of abuse, neglect, and sexual abuse. Emphasis on working with older children to incorporate health into educational activities; modeling good health and sanitary habits; responding appropriately to toddler's curiosity about their bodies; linking nutrition and health through activities for the children. Omits washing of children's hands; omits cleanliness of bed linens; individual towels, change of clothing. Criteria are stated but not defined; presumes a universal understanding of good health practices. Omits provider's knowledge of CPR; does not prohibit smoking.	Emphasis on healthy environment; disinfected bathrooms, changing tables, and toys; clear definition of disinfectant to be used on materials and toys; daily diaper disposal; adequate heating and ventilation. Emphasis on personal hygiene of provider and children; washing hands after toileting, diapering, nose blowing, handling a sick child; provision of clean or disposable towels for individual use; clean bed linens for each child washed weekly; change of clothes and personal items such as toothbrush available; soiled clothes sent home daily. Emphasis on recognition of clearly-defined physical and behavioral symptoms of illness, neglect, abuse or sexual abuse; isolating ill children; contacting parents; provider has permission forms for medication; provider does not smoke in the presence of children. Provider has access to Ipecac, First-Aid supplies, and training in First Aid, CPR; provider has written instructions for treatment of illnesses and minor injuries.	Emphasis on a healthy environment; adequate ventilation, lighting, and room temperature; clean play areas; bathrooms cleaned as needed; disinfects all shared toys "mouthed" by infants/ toddlers once a day; kitchen reasonably clean; safe and sanitary procedure for diaper changing. Emphasis on personal hygiene; washing hands with soap and water before mealtimes and after toileting for children; before and after diapering, toileting, preparing or serving food, and nose-blowing for provider; provides each child with own towel or paper towels are used; washes bedding at least weekly, more often if needed. Knows how to recognize and report possible abuse and neglect; has a procedure for isolating sick children when needed; enforces rules for attendance during child's illness; provider has permission forms for medication; provider does not smoke in the presence of children. Provider is trained in First Aid, CPR and has First-Aid supplies available. Omits criteria for recognizing symptoms of illness; unclear criteria for cleanliness and disinfecting.	Emphasis on basic health care; First-Aid kit available; knowledge of treatment of minor injuries; does not accept ill children into care; "can administer prescription drugs"; knowledge of action for child with symptoms of serious illness. Assumes providers have met health criteria of Pennsylvania licensing regulations for a healthy environment(some of the following may be included there). Cleanliness of environment is not addressed; personal hygiene of provider or children is not addressed; emergency provisions (phone lists, other adult assistance, health resources, communication with parents) are not addressed; provider's knowledge of CPR not addressed. Does not prohibit smoking.	Inadequate: Poor sanitiation, inadequate toileting/diapering, unclean cooking/eating area. Minimal: Basic sanitary conditions in food preparation, diapering/toileting area. Provider washes hands after diapering/toileting, and washes children's hands after toileting. Good: Area used for child care has good light, ventilation, and temperature; emphasis on sanitary procedure to avoid the spread of germs when diapering and toileting children; disinfects surfaces; disposal of diapers in a covered can; avoids using potty chairs since they must be disinfected after each use; washes all toys at least weekly; floors disinfected frequently; cleans feeding chairs with sanitizing solution. Provider notes allergies and unusual behavior; administers medication only with written permission. Provider has emergency care and health records (including immunization) for each child; keeps parents' work phone numbers; reports suspected child abuse; has own yearly health exam. Excellent: Diapering/toileting used as time to talk with and relate warmly to children and promote self-help in cleanliness and dressing; bed linens washed weekly; personal items available (each child has own toothbrush, towel/washcloth, extra clothes); provider has arranged contact with local medical professional for questions; health information provided for parents; incorporates good health habits into daily care (storybook about health, nutrition activities). Omits provider's knowledge of CPR; does not state criteria for recognizing symptoms of illness.

	CDA	NAFDC	Dallas	Louise	FDCRS
Safety	Emphasis on safe environment to prevent and reduce injuries; removal of debris, toxic plants, and cleaning materials; no lead paint or asbestos; child-proofed stairs, electrical outlets, appliances, secured furniture. Emphasis on supervision in the kitchen, outdoors, and while traveling; use of car seats; maintenance of outdoor play equipment; equipment must be cushioned underneath for safety. Emphasis on provider's skills and knowledge of first aid, use of fire extinguisher, emergency procedures, emergency phone list, resources, evacuation procedure; practices monthly fire drills; other adult listed for emergencies. Emphasis on provider's differential treatment of infants, toddlers and preschoolers; holds toddler's hands when near dangerous areas; teaches preschoolers simple safety rules; careful monitoring of infants while sleeping; crib side rails locked when infants are in them; stays with infants while diapering, explicit rules for toddlers and preschoolers focusing on cause and effect.	Presents four distinct areas with well defined criteria for safety: Diapering/Toileting: toilet and potty provided where necessary; provisions for child's use of adult-sized sink; door locks out of reach; dangerous objects in bathroom removed (razors, medicines, etc.) Kitchen: child-proofed appliances, removal of cords, matches, knives, cleaning products; adaptive seating; children supervised in kitchen at all times. Sleeping Area: cribs/beds/cots are available, minimum of two feet between them, cribs are secure to prevent climbing out. Arrangement of Indoor Space: child-proofed toys, no small parts that could be swallowed; secure furniture; dangerous items stored; hazards removed (cords, sharp edges, fans, heaters, poisonous plants); child-proofed stairs, electrical outlets, furniture; fire extinguisher and smoke detector; floors and doors in good repair; doors and windows screened. Emphasis on knowledge and practice of emergency procedures, evacuation, emergency phone list, other adult listed for emergencies.	Emphasis on safe environment indoors; kitchen area safe; safety locks on cupboards; cleaning materials and harmful materials and utensils out of reach; screens on windows and doors; child-proofed stairs, electrical outlets, appliances; walls and surfaces free from chipped and peeling paint; cribs are secure and slats no more than 2-3/8" apart; play equipment in good repair (no loose screws, protruding nails); no small objects that toddlers can swallow. Emphasis on supervision; appropriate car restraint devices; supervision around water and pools at all times; keeps play yard free of debris and hazards, poisonous plants, and dangerous substances (bug spray, gasoline). Emphasis on provider's preparation and skills for emergency situations; practices fire drills and posts evacuation plan; emergency phone list; has a working phone; fire extinguishers and smoke detectors are in place and operable; provider knows how to use them.	Emphasis on safe environment "without being overly restrictive"; provider knows where children are; is within hearing distance of children; prevents children from hurting each other; prevents dangerous situations. Emphasis on safety indoors and outdoors; gates and fences where necessary; stairs and other dangerous areas blocked; harmful materials such as lye, bleach, and drugs out of reach. Emphasis on plan for medical emergencies; telephone available; emergency phone numbers posted, plan for emergency transportation. Assumes providers have met safety criteria of Pennsylvania licensing regulations (some of the following may be included there). Omits specific areas that must be child-proofed (kitchen, bathroom, cribs, electric appliances); does not focus on provider's supervision or statement of rules to children; omits provider's skills and knowledge of CPR, First- Aid, and emergency procedures; omits use of fire extinguisher, smoke detector.	Inadequate: Indoors - no caps on electrical sockets, loose electrical cords, cleaning materials and other dangerous substances not locked away, trash accessible, pot handles on stove accessible, toy box with heavy lid, crib or playpen slats too far apart, mats or rugs that slide, toys or pieces that can be swallowed, open stairs accessible. Outdoors - tools accessible, garden sprays accessible, tool shed or garage unlocked, poisonous plants around, unsafe play equipment, unsafe walkways or stairs, easy access to road. Good: Phone in home and transportation available for emergency use; provider has had First-Aid training; Frst-Aid supplies stocked; emergency phone numbers posted; alternate care available for emergencies; emergency exit plans posted and practiced monthly; provider uses car seats; no obvious safety problems indoors or outdoors (see above). Emphasis on sufficient furniture for all children that is safe and in good repair; soft furniture available (carpeted area, sofa, soft chairs, stuffed animals). Excellent: Provider trained in CPR, safety rules taught to children; safety information shared with parents (pamphlets and safety tips). Some child sized furniture and soft furnishings provided (floor cushions, beanbag chairs, child-sized rocker). Omits use of fire extinguisher, smoke detector.

	CDA	NAFDC	Dallas	Louise	FDCRS
Nutrition	Emphasis on balanced meals; "Provider learns about good nutrition for children from birth to five and plans and prepares age-appropriate, nutritious meals and snacks." Infants are held when fed, provider responds to individual rhythms while working toward regularity; infants are given only water bottles in bed. Meals are pleasant and relaxed; provider includes children in food preparation; communicates with parents about good nutrition; limits salt, sugar, processed foods, chemical additives, colorings, and flavorings. Emphasis on integrating nutrition into toddler's and preschooler's development and education via materials, role modeling, and activities. Omits provisions for children with allergies or special nutritional needs.	Emphasis on balanced meals; food portions comply with USDA standards; second portions available; provisions made for children with allergies or special nutritional needs. Infants are held when fed; provider must respond to infant cues or feed according to schedule specified by parents. Children eat at their own pace; are involved in food preparation and clean-up; provider is involved with children during meals; uses meals as an educational language experience (labeling foods and relevant conversation); children are not forced or coerced to eat.	Emphasis on balanced meals; must meet USDA standards; menu planned a week in advance and posted; meals and snacks are on a regular schedule. Special allergies to food, medicine, or environment are posted. Infants are held when fed; no bottle props; children who are ready are allowed to feed themselves. Baby bottles are individually coded, covered, and refrigerated. Provider sits with children during meals. Omits nutrition education.	Emphasis on balanced meals; morning and afternoon snacks; seconds available; food preferences accomodated; sufficient time to eat; age-appropriate seating (high chairs); meals are a pleasant time; children are encouraged, not forced or coerced, to eat. Emphasis on feeding infants; responding to infants cues when hungry; not using bottle prop; infants not physically restrained. Omits nutrition education, and provisions for children with allergies or special nutritional needs.	Inadequate: Nutritional quality questionable, children take bottles to bed. Minimal: Well-balanced meals/snacks served on a regular basis. Good: Careful organization of meal times, waiting prevented. Meal times pleasant. Excellent: Parents made aware of menus. This instrument does not specify nutritious standards for evaluating meals. Omits provisions for children with allergies or special nutritional needs; integrating nutrition into children's education.

	CDA	NAFDC	Dallas	Louise	FDCRS
Family Support and Interaction	The provider maintains an open, friendly, cooperative relationship with each child's family; the parents and provider become partners who communicate openly and respectfully for the mutual benefit of the children. Provider encourages parents to talk about family events and their children's special interests; encourages parents to visit FDC home, participate in activities and make suggestions; is able to discuss problem behavior with parents; suggests activities and materials parents can share with children at home; respects parents' views when they differ from provider's goals or policies and attempts to resolve the differences. Provider responds to concerns of parents about infant's and children's developmental stages (sleeping, feeding, separation, rituals and routines, setting limits, toilet learning, emotional outbursts); provider makes suggestions to parents about how to respond to and stimulate infants and children in developmentally appropriate ways; works with parents to prepare children for entering school; maintains confidentiality. Recognizes the different relationship with FDC children and own children; gives each child special attention and lets own children keep toys or space just for themselves. Helps parents identify resources to diagnose and treat children with handicaps, and obtain information about their children's handicaps and their legal rights to services.	Parents complete a child information form at enrollment; provider plans opportunities to share information with parents regularly; talks with parents at arrival and departure about the day's events and experiences; a chart or form is available and used to record variations in a child's routine (eating, sleeping, toileting); invites parents to participate in FDC activities; at least one time a year provider schedules an individual meeting with parents when child is not present. Parent survey for accreditation assesses parents' perception of communication with provider. Omits responding to parents' concerns about discipline; discussing developmentally appropriate materials, activities with parents; helping parents find resources for special needs. Does not address the relationship between the provider, her own family and children, and the families and children in her care. Does not address sensitivity to cultural differences.	Providers must work closely with parents to support them in their child-rearing efforts. Emphasis on provider and parents working together to set consistent, age-appropriate limits; helping parents to learn positive ways to guide their children. Provider greets parents and children individually at arrival and departure, and informally shares information about the child (e.g. sleeping/eating patterns, play, changes in behavior/health, toileting patterns). Encourages and welcomes parents to participate. Observes strict confidentiality regarding children and families. Omits discussing developmentally appropriate materials, activities with parents; provider responding to parents' concerns about: eating/sleeping patterns, toilet learning, discipline. Omits helping parents find resources for special needs. Does not address the relationship between the provider, her own family and children, and the families and children in her care.	Level One: Can cooperate with parents in toilet learning and weaning. Level Two: Indicates respect for parents' role as primary caregivers; attempts to coordinate efforts at weaning, toilet training and self-care with parents; consults with parents on child's food preferences, eating, and napping patterns; consults with parents when encountering difficulties with the child; discusses child's progress, events of the day with parents; provider discourages the child from calling her "mom." Level Three: Shows competence in relating to parents in a non-judgmental manner; reports concerning parents are not overly critical; maintains the bounds of confidentiality. Omits involving the parents in FCC activities; helping parents find resources for special needs; responding to parents' concerns about discipline; discussing developmentally appropriate materials, activities with parents. Does not address the relationship between the provider, her own family and children, and the families and children in care. Does not address sensitivity to cultural differences.	Minimal: Parents can visit while child attending. Good: Parents welcomed as visitors; provider tells parents about child's activities at least once a week and works cooperatively with parents to address toilet learning, discipline methods. Emphasis on balancing personal and caregiving responsibilities; provider plans so that personal responsibilities and child care program seldom interfere with one another. Excellent: Provider gives daily report to parents about child's activities; parents encouraged to share skills and interests with the child care home (bring in materials, help with field trips). In order to balance personal and professional responsibilities, provider uses household jobs as learning activities (bake bread, sort and fold clothes). Omits discussing developmentally appropriate materials, activities with parents; helping parents find resources for special needs. Does not address the relationship between the provider, her own family and children, and the families and children in her care.

	CDA	NAFDC	Dallas	Louise	FDCRS
Professionalism	Program Management: Maintains up-to-date records concerning growth, health, behavior, progress of each child, and shares them with parents; keeps up-to-date records (tax records, Child Care Food Program records, medical information, payment records); cooperates with program personnel when involved in a satellite or network; plans for substitute care for emergencies and planned occasions; chooses substitutes carefully and orients them to routines and needs of children; knows the social service, health, and education resources of the community and appropriately uses them. Professionalism: Provider can describe child care philosophy, goals; continues to gain knowledge of physical, cognitive, language, emotional, and social development and keeps informed about child care practices, research, legislation by seeking information from professional literature, community colleges and resources; joins professional organizations, attends meetings, training courses, conferences; keeps up-to-date on laws and policies about reporting sexual abuse and child abuse and neglect; learns effective ways of working with affected children and families. Omits written policies for parents: fees (rates, late fees, payment schedule); hours; late pick-up policy; procedures for vacation, illness; procedures when someone other than parent picks up the child; description of program (philosophy, daily routine, types of activities, approach to discipline). Omits provider retaining primary responsibility for child except when formal substitute has been arranged.	Emphasis on comprehensive, written policies for parents: fee payment guidelines (rates, late fees, payment schedule, child illness and vacations); hours of operation; late pick-up policy; procedures for parent notification and provision of care when provider cannot be available (vacation; illness; professional development), including 2 weeks notice to parents; procedures when someone other than parent picks up the child; description of program available (philosophy, daily routine, types of activities, approach to discipline). Emphasis on responsible health practices; guidelines for identifying symptoms of illness and arrangements for notifying parents and handling emergency situations. Immunization records available for all children; signed, emergency medical release forms; provider follows up status of health care and referrals; forms are available and used for recording information about allergies and special needs. Emphasis on provider's ongoing professional development; takes part in workshops, conferences, professional affiliations; reads books and resources; knows community resource to whom suspected child abuse is reported. Provider writes yearly reports on program growth and goals for coming year. Third update requires development of a résumé. Omits provider retaining primary responsibility for child except when formal substitute has been arranged; omits provider's ability to describe program to parents.	"The business of family/home child care involves using the home as a place to professionally care for ther people's children. As a business person the provider needs to be a careful planner, organizer and record-keeper and...needs to be informed about tax laws, insurance requirements and local/state registration requirements for FDC." Emphasis on record keeping, written policies given to parents: hours of care, fee and payment schedule, refunds; vacations/holidays; philosophy/goals; guidance methods used; emergency procedures; authorization for pick-up of children; policy regarding care of sick children; permission forms for trips; substitute plan. Omits provider's participation in ongoing professional development; omits provider's retaining primary responsibility for child except when formal substitute has been arranged; omits provider's ability to describe program to parents.	Program Management: Emphasis on provider's accurate reports to supervisor/agency regarding children's activities and absences, provider's own absences, relationship with the parents; provider "retains primary responsibility for the child"; provider reports changes in behavior and shows competence in the observation of unusual behavior (e.g., affect level, activity, eating and napping patterns, motor coordination). Professionalism: Provider comes to in-service training; consults with supervisor for alternatives to physical punishment and advice in programming. Emphasis on competence as a teacher; allows observers in her home; is capable of self-evaluation; is capable of changing an approach when it isn't working; keeps phone calls and neighbors visits to a minimum; is open to advice from consulting psychologist. Omits written policies for parents: fees (rates, late fees, payment schedule, child illness and vacations); hours; late pick-up policy; procedures for vacation, illness; procedures when someone other than parent picks up the child; description of program (philosophy, daily routine, types of activities, approach to discipline). Omits provider's ability to describe program to parents.	Good: Written child care policies and rules given to parents (payment schedules, hours of operation, absence policy, parental responsibilities). Provider regularly takes part in professional development activities (attends 2 workshops, takes one course or has 2 on-site training visits each year); regularly reads child care books or magazines on child rearing. Excellent: Provider is an active member of a early childhood or child care professional group. Participates in professional development programs or activities at least 4 times a year. Omits provider's ability to describe program to parents; omits substitute plan; omits provider retaining primary responsibility for child except when formal substitute has been arranged.

Part 3. A Tentative List of the Pros and Cons of the Instruments

No one of these instruments is the best — each has its pros and cons. Part 3 attempts to list some of pros and cons of each one, so that their potential for effectiveness can be evaluated within the context of the situation. Part 4 presents a discussion of related issues, and Part 5 draws recommendations.

The reader must realize that these are only tentative conclusions, based on the interviews and analysis of this study. They are offered to stimulate dialogue and debate in the field.

CDA

Pros

- Gives the most comprehensive description of quality; explains the rationale and attitudes behind competent behavior. Considers the meaning of children's behavior and identifies developmentally appropriate practice for different ages.
- Allows for flexibility and individual difference in provider style and ways of demonstrating competence .
- Addresses the needs of infants and toddlers as well as preschoolers (not school-agers). Recognizes the importance of inter-family relationships. Stresses multicultural approach.
- Useful for training or self-improvement; helpful for experienced providers as well as those who "have a long way to go."
- Promotes a high level of quality, although accepts a fairly broad range (depending on assessment team's judgment, a competency may need to be demonstrated only once or many times in a range of ways).
- Nationally recognized.

Cons

- Some criteria are vague and hard to assess, allowing for evaluators' interpretations, and bias (other criteria are specific and clear). Omits non-sexist learning. Requires evaluators who understand child development.
- Training and support is necessary to make CDA work for many providers, but may be unavailable.
- Writing requirements necessitate a relatively high level of literacy. Quantity of written material can be overwhelming .
- More complex and time-consuming than other approaches.
- Does not differentiate between moderate and high quality care.

NAFDC

Pros

- Clear, objective definitions of behaviors to be validated (less open to interpretation).
- Defines a moderate level of quality and professionalism; comprehensive description of written policies.
- Recognizes the quality of providers who do not act as traditional teachers but who set up a challenging environment and have high quality interactions with children.
- Assesses parents' attitudes.
- Introduces providers to their professional association.
- Nationally recognized.

Cons

- Limited assessment of provider's extending and facilitating play, more focus on materials; limited assessment of needs of infants and toddlers; omits multicultural and non-sexist learning.
- Providers can achieve accreditation while failing to meet several important criteria (no weighting of most important items).
- List of examples of materials required for different developmental areas includes only commercial materials, not materials found in most homes or home-made.
- Does not differentiate between moderate and high quality care.

Dallas

Pros

- Defines a fairly high level of quality in clear, specific language.
- Simple, straight-forward, much easier to administer than the CDA. Does not require parent evaluators (which are often hard to find). Cost-effective for agency.
- Criteria are used to define quality in training sessions, which offer examples and rationale behind criteria. Helpful for providers who "have a long way to go."
- Addresses some of the needs of school-age children; includes multicultural learning.
- Results highly correlated with the FDCRS (Nelson, 1989).

Cons

- Omits non-sexist learning.
- Does not differentiate between moderate and high quality care.
- Training component requires additional funding.
- Not recognized outside of the Greater Dallas area.

Louise

Pros

Simplest instrument to use, quick and cost-effective for an agency to administer (the authors are developing an even shorter scale).

Because it is easier to achieve the first rung of success on this evaluation compared to the others, it probably "passes" more providers. In some situations it is useful to acknowledge providers who are at Level 2, offering Intuitively Good Care, which might encourage them to strive for Level 3.

Allows careful assessment of positive child guidance/discipline.

Cons

Not intended for use in accreditation; this instrument was designed to assess the quality of the provider-child interactions. Does not thoroughly assess different areas of development (see grid), level of children's engagement in activities, multicultural and non-sexist learning (The authors believe providers need training to understand how to implement a child-responsive curriculum.)

Some criteria are vague and hard to assess (may be eliminated in new instrument); requires an observer who understands child development.

Does not differentiate between moderate and high quality care.

Not recognized outside of Pittsburgh.

FDCRS

Pros

Top of scale differentiates a high level of quality, except for areas omitted (see grid); includes multicultural and non-sexist learning.

Several levels of acceptable quality (from "minimal" to "excellent" rather than "yes" or "no") allow recognition of differential competence. Defines inadequate care, and next-level goals for providers' improvement.

Fairly quick and cost-effective to administer.

Nationally recognized.

Cons

In order to be rated good or excellent on some items, a provider must act like a teacher, scheduling planned activities; does not recognize high quality in a provider who is like a good parent.

Limited assessment of provider's facilitating and extending spontaneous play; omits level of children's engagement in activities.

Part 4. Discussion

Many interesting issues are raised as we compare the instruments, and try to decide which one will be most useful for any particular purpose. This section attempts to clarify the issues raised and comment upon them. Again, the reader should understand these opinions and interpretations are offered to stimulate dialogue.

How Does "Quality" Look Different in Family Child Care Compared to Center Care?

We have not thoroughly explored this question. To varying degrees, all of the instruments for measuring family child care quality were derived from center-based approaches. The FDCRS was fashioned after the Harms-Clifford Early Childhood Environment Rating Scale for centers. The family child care CDA was developed after the center-based CDA. Sibley and Abbott-Shim designed a center-based evaluation before they developed NAFDC's assessment instrument. Dallas used the CDA extensively. This is not to say that there weren't providers and others familiar with family child care involved in designing all the home-based instruments — but how might they have been different if they had been created for family child care from scratch? What might have been overlooked? Is this why the criteria often pertain more to 3-5 year olds than infants and toddlers or school-agers? Many people interviewed shared my concern that we have not fully identified the special characteristics of family child care quality.

Provider Style. From my own observations, I would say that there are two basic styles of good family child care providers. One type is the provider who is like a good preschool teacher. She is warm, loving, and responsive to the children. Her house, at least during the week, looks like a mini-preschool. There are shelves displaying an interesting array of toys and materials. The planned activities may include a circle time with songs and group discussions.

The other type of good provider is like a good parent. She too is warm, loving, and responsive to the children. But that is where the resemblance ends. Her home may look like any large family's home: quite a few toys, perhaps not well displayed, a couple of high chairs, more than one riding toy. But the materials and equipment are not distinguishing. What is exceptional is "her way with children." All the children are playing together like one big happy family. The 3-year-old is playing peek-a-boo with the baby, and it's hard to tell which one is enjoying it more. Two children are busy peeling the carrots for lunch. The morning outing always includes checking in on an infirmed neighbor, and usually produces an addition to the science collection. The children are seldom bored. The provider finds opportunities in everyday routines to help meet each child's needs. For some children her style is ideal.

The assessment instruments in this study are good at spotting the quality of the "good teacher" provider. They tend to under-rate the "good parent" provider. For some children, the latter would be the better provider. The field of family child care needs to recognize these special providers within our midst. We need to identify what it is that they do well, so that we can include it in training as well as accreditation and research.

The Role of Planning. The importance of curriculum planning is another key example. Planning has become an indicator of center-based quality because good center activities must be coordinated among several different staff members. A group might plan to use the playground from 11:15-12:00 because other groups are scheduled to use it before and after that time. In family child care, the provider can take the children outside when the weather is best and the children are ready for active play, working around their individual needs for naps.

A center group might schedule their visit to a hospital two months ahead, because they have signed up to use the center's hospital play props and curriculum materials that month. In a good home program, a provider might take children to visit a hospital or clinic if one of the parents is scheduled for surgery or expecting a baby. A few days in advance she might arrange for a substitute caregiver, so the little ones can stay at home. On the way back from the hospital they might stop at the library for some books about hospitals, or human bodies, or babies. The next day they might improvise some hospital play with the furniture and some old sheets. But in many good homes, most of the activities are more spontaneous than planned.

While a daily schedule, planned in detail, is unnecessary and usually undesirable in family child care, ideally the provider does more than simply prepare a rich environment and let the kids play. Some kinds of play do not occur automatically, even though the materials are available. A provider can ensure a wide range of good play through introducing new activities and extending spontaneous ones. Children benefit from her observing their individual needs and interests, and facilitating their play accordingly. She may look like a traditional teacher sometimes, or she may achieve her purposes in less direct ways. A lot of the time she follows the children's lead.

Family child care can be more flexible than large-group care. A provider who does not schedule daily activities should have some interesting and different activities "up her sleeve" for times when good spontaneous play isn't happening. Some providers acquire these skills on their own; others learn them through training and/or interactions with other child care professionals.

What Does "Education" Look Like in Family Child Care?

Family child care can be just as educational as center-based or public school programs, for any age child — but high quality education looks different in a home setting with fewer children than it does in an institutional setting with lots of children.

In the National Association for the Education of Young Children, there is consensus that the right kind of education for young children is based on what has come to be called "developmentally appropriate practice." This concept is well presented in the book *Developmentally Appropriate Practice* (NAEYC, 1987). While, unfortunately, this book was written with only center- and school-based programs in mind, the concepts apply equally well to family child care. Essentially, it suggests that providers should prepare an environment in which children can explore and learn through active play and interaction with the provider, the other children, and the materials. Instead of isolated lessons run by the teacher, activities should be "hands on" and meaningful in the context of the child's daily experience. Providers should extend and facilitate play based on what they have observed of individual children's needs and interests. Family child care can be an ideal setting for ,state-of-the-art early childhood educational practice.

A high-quality provider is good at seizing the opportunities and teachable moments that present themselves every day. In addition to involving children in routines like preparing meals and washing toys, they can help to fix a wobbly chair or a dripping faucet. The back yard offers opportunities to watch what insects are doing, and what happens when you dig a hole and pour in water. A trip to the corner store can involve writing and reading a shopping list, using classification to find the fruits and vegetables, and counting change. This is developmentally appropriate curriculum at its best.

If a provider does these things, she is as much a "teacher" as anyone — and her program is as "educational" as any in other settings — even though she may reject these terms because they convey different meanings to her.

Do High-Quality Programs Have to be Educational?

This question is being debated in the field and different answers are reflected by the different instruments. Harms and Clifford are explicit about their position:

> The FDCRS tries to remain realistic for family day care home settings by not requiring that things be done as they are in day care centers. Yet a family day care home should not be thought of as simply the private home of a family; it must provide the necessary additional organization, space, materials, activities, and interaction to give developmentally

appropriate experiences to the children who are enrolled there for day care. (p.1)

The CDA suggests that the provider can use "the home environment, everyday activities, and homemade materials to encourage children's intellectual development." (p.31) Yes, but how? We need more elaboration of this type of curriculum.

In some states, a single provider can be licensed to care for 12 children. Market rates may force her to take her full quota of children to make a living wage. Can the most talented of providers put together an individualized, developmentally appropriate program in this situation? Or can we ask only that she provide good basic care: nutritious meals served in a pleasant atmosphere, diapers changed, toilet learning facilitated, hands washed, a hug, cleaning, and bandaid for a scraped knee?

How do we recognize the important contribution of a provider who is offering good basic (custodial) care, but also insist that children deserve education as well as care? How can we promote quality in states where regulation is weak or non-existent?

What Are Other Special Qualities of Family Child Care?

Another central feature of good family child care is the quality of relationships between the provider and each child. These can be more intimate in family child care than center care, because there are fewer children and many of them stay with one provider for years. Providers are especially able to listen carefully to individual children, carry on extended conversations, understand nuances of children's behavior, customize activities to meet their needs, "be there" for them. CDA and NAFDC assess this feature; it is not fully tapped by the other three instruments.

Families are a greater part of good family child care than they are of most centers. Providers can have closer relationships with parents, and often the provider's family and children's families socialize together and support each other beyond the weekday child care (Windflower Enterprises, 1988). Only the CDA emphasizes the relationships among families.

The mixed-age groups that occur naturally in family child care offer wonderful opportunities for children to learn from other children, and to teach and care for others. Only the CDA emphasizes this special aspect of family child care. None of the instruments focuses on the care of school-aged children, but some of the best school-age care happens in child care homes.

Finally, I feel that there are some factors related to providers' working conditions that influence quality and are different from those in centers. Providers need to do something to overcome their isolation. They need vacation time — working 50-65 hour weeks for 52 weeks per year with no substitutes, as many providers do, is not conducive to quality. These indicators of quality need to be added to the instruments.

How High Should Standards Be?

Several interviewees who have been working with accreditation raised the question, "How high should accreditation standards be?" Clearly each instrument represents a higher standard than the minimums set by licensing or registration in most states; most approve moderate-level quality. Is that high enough?

It depends. Standards, if they are to meet the needs of the whole community, not some elite group, should not be so high that they are beyond the aspirations of most providers. Nor should they be so low that they don't mean much, and imply that quality in family child care is not important. Is the purpose of the accreditation to recognize quality where it exists, or to stretch providers to higher levels? Is there funding available to help them stretch, or is there a highly committed and competent group of volunteer-mentors willing to help? Standards can be set higher when assistance is available to providers trying to improve their practice, through training and/or individual support.

Consider an example from child care center accreditation. The first task of the Dallas Partnership was to select a method to accredit centers. Their laudable and ambitious goal was to upgrade the quality of care in the city of Dallas. Some people wanted to use the National Association for the Education of Young Children's Accreditation (1984, 1985). Others felt these standards would be beyond the reach of most of the city's centers. The first group prevailed with the argument that the city shouldn't certify second-class quality. Thanks to major efforts including a great deal of high-level, volunteer technical assistance, they have accredited more centers than any other city in the United States, and together with family child care training and accreditation they have truly upgraded the quality of child care in Dallas.

Others, especially those who do not have such resources and/or are fairly satisfied with the level of care that exists in many homes, argue that accreditation standards should be moderate and attainable by the average person with a reasonable amount of effort.

Cultural and value differences influence peoples' judgment of level of quality. For example, one of the most lively debates is over television watching. NAFDC allows children to watch two hours of TV per day. "No more than 2 hours daily" is the criterion for minimal-level care on the FDCRS; excellent care requires that TV not be used at all, or that it be planned as an educational experience with provider involved, and some play activities planned to follow up on programs. (Other instruments dodge the question by saying that TV

watching should be limited without specifying how.) Some people believe that in a good child care home, children do not watch TV every day. Others can't imagine not having the TV on for at least a few hours every day.

Other cultural differences influence our judgment of quality. For instance, in the United States we tend to place a great deal of emphasis on developing independence and autonomy in young children. Many cultures prefer to emphasize interdependence — cooperation and taking care of each other.

One quality indicator that is missing in all the instruments is a limit on group size and compositon. The authors tend to require that providers follow state regulations. But regardless of legality, you can't have quality when one provider must care for 10 or 15 children, or several infants.

The level of state regulatory requirements influence our judgments about how high accreditation standards seem. Standards that seem quite low in one state may seem unreasonably high and difficult to achieve in another. What are the implications for national standards and national accreditation tools?

Should Evaluation Criteria Define Specific Behaviors or General Competencies?

The instruments differ greatly in their specificity. The designers of the NAFDC, Dallas, Louise, and FRCRS instruments attempted to avoid vague terms. As much as possible they have tried to make checklists that spell out specific behaviors which everyone can recognize. Providers are evaluated on every criteria.

The CDA takes a different tact. It defines general competency areas, then gives a range of possible examples of how a provider might demonstrate them. It is up to the team members to look for any ways that the general competencies are met by the provider. On the one hand, this approach is flexible and allows for creative individual differences in providers as well as differences in community values. The important "big picture" is not overlooked as it can be by instruments that rely entirely on specific behavioral criteria. On the other hand, the CDA is interpreted differently by different teams. In one community where the CDA Rep has high standards, CDA providers are reputed to be of very good quality and the CDA Credential is highly respected. In another community, "almost anybody can get a CDA if they go through the red tape." This approach is also more vulnerable to bias, cultural prejudices, and individual variations in standards. In researchers' terms, the CDA sacrifices some reliability in exchange for higher validity. By design, the reliability is not in the instrument, but in the team. (It should be noted that the CDA also contains many statements in clear, specific language.)

Is it possible to assess all aspects of quality in behavioral terms? The mood and atmosphere of a home is important, but its evaluation would necessarily be influenced by individual interpretation. Can concrete criteria be accurately assessed without understanding their meaning or rationale? Probably not.

Instruments that look for specific behaviors sometimes miss the woods for the trees. For instance, a provider can display all the right behaviors for the FDCRS and Louise scales, while at the same time showing only superficial relationships with the children. And the children can be bored, not engaged in meaningful play.

According to developmental theory, nothing is more important for very young children in child care than the quality of their relationships with the caregiver(s) — hard to define by specific behaviors. The Dallas evaluation has managed to achieve a middle ground in its approach. It captures some elusive qualities in language that it seems most people would understand and apply the same way: "Plays and smiles with all children during routine times (feeding, bathing, dressing)," "Listens and responds to children's concerns," "Comments directly and positively to children about themselves, their performance and ideas." (pp. 25-26) (The last example was taken from the CDA.) Again, the success of this approach depends upon a competent assessor.

Finally, evaluation always involves a degree of interpretation. "Objective" language, for example "encourages eating," suggests different behaviors to different evaluators. All of these instruments are only as good as the people using them.

Are The Results of These Assessments Accurate?

As indicated, there may be several important aspects of family child care quality that are not tapped by the instruments. This raises the question of their validity. Are they really measuring quality in all its facets? We need more dialogue and more research on the unique aspects of quality in home-based programs.

Where possible, items should describe clearly defined "objective" behavioral criteria. They are more reliable and less vulnerable to evaluator bias. But important traits like the provider's attitudes toward individual children, the home's atmosphere, and the quality of children's play should be included even if they can't be specified in behavioral language.

How much of a particular kind of behavior is enough? A typical criterion is "Provider initiates positive verbal exchanges." Two positive exchanges over the course of a morning would qualify for a check on the checklists. Is that enough? And what if they are trivial verbal exchanges, versus ones that are meaningful and interesting to the child? Here the CDA approach of assessing overall competence

rather than particular behaviors is theoretically more valid in spite of the reliability problems.

There are other methodological concerns as well. When a behavior cannot be observed, evaluators are usually instructed to interview the provider. Is it reliable to ask a provider, for instance, whether she puts away toys that the children aren't using? If the question is asked more obliquely, ("Can you tell me any ways you have changed this room this month?") the provider may neglect to report good examples. Can the evaluator be sure of getting accurate information?

What about the inconsistencies in any program from day to day? One day finds the children full of great ideas for activities, loving, and friendly. The next day they are impassive, unresponsive, and cranky. What can an evaluator conclude from a one-day visit?

Various versions of the FDCRS have been found to have inter-rater reliabilities ranging from .83 to over .90. Its validity was supported by its correlation with the Dallas in one study.* The CDA was field-tested extensively to achieve satisfactory reliability and validity, as was an earlier version of the Louise instrument.

How Useful is Accreditation Without Training?

It is possible to have accreditation without training. The advantage of such a program is the recognition it brings to providers who are doing a good job. Further, through self-evaluation and study, a motivated provider can identify areas she wants to improve, then seek information and support. If she lives in a community that has good resources, this process may be extremely helpful. But given the lack of public recognition of accreditation at this early point in its history, she must have personal reasons for going to the effort.

Bill Hignett and Roberta Schomberg of Louise Child Care make the point that it is important to offer training to providers before they are asked to implement an educational curriculum. If they try to foster cognitive development before they understand how young children learn, they are likely to offer inappropriate activities. (This also happens when untrained providers try to respond to parents' requests for educational activities, e.g., teaching two- and three-year-olds to identify states on a map.) If good training is not available, Hignett and Schomberg suggest that it is best to help providers learn to tune in to and respond to children's cues.

The research on quality in child care centers suggests that training is strongly associated with improving quality of care. All five of these instruments could be useful in training programs. They introduce concepts of quality and help providers define what they want to improve. This study suggests that no one instrument assesses all aspects of family child care quality. Trainers might benefit from supplementing their primary assessment system with additional criteria and rationale.

Two qualities are necessary in effective trainers. One is that they really understand child development, business management, and the other content areas to be taught, and the other is that they have first-hand experience in family child care. See *The Provider Connection* for a discussion of the importance of involving providers(Windflower Enterprises, 1990). This expertise can be offered by a team of two who work well together.

Training programs can provide the structure as well as the content for improving quality. The Dallas Partnership staff feel that their training is the key to their success. Houston's Initiatives for Children uses training in conjunction with NAFDC Accreditation, because they want a nationally relevant assessment. Many other agency people cited the need to "hold providers' hands" and "walk them through the process." The most effective people for this role are other providers or ex-providers who can serve as mentors to newcomers.

Unfortunately, advanced training is not offered in many communities. Most programs offer basic orientation and start-up training only. Why do some people think that early childhood teachers in the public schools or good child care centers should have B.A.s or M.A.s, but family child care providers need no training? This implies that no knowledge or skill is required to do this job, or perhaps that women just naturally know how to do it. From my own experience, and that of others I have observed, this simply is not true. Child care is an incredibly complex art and science. Just because providers are not usually trained does not mean that they would not benefit from training.

There are two pragmatic reasons for the lack of advanced training. Providers make so little income that they cannot afford tuition, especially since increased training does not usually result in higher income. (The new legislation for CDA scholarship funds may allow states to allocate some scholarships for training.) Because most providers work 10-12 hours per day, and spend some weekend hours on child-care-related activities, it is hard for them to find the time to go to classes and do homework.

* In an unpublished study of 32 San Antonio providers who had been assessed by the FDCRS, Dallas, and NAFDC insatruments, Nelson (1989) concluded that the Dallas instrument is more valid than NAFDC's, because it correlated more highly with the FDCRS. But there are several methodological concerns about this study. Most basically, the study assumes that the FDCRS is a completely comprehensive measure of quality; but it could be that the NAFDC doesn't correlate so highly with the other two because it measures different but equally important factors.

Could There Be One Nationally Recognized Form of Accreditation?

As it stands now, the Dallas Accreditation is meaningless in other cities. Similarly, a high score on the Louise scale is not worth much to the provider who moves away from Pittsburgh. Someone with NAFDC accreditation is not eligible for benefits available to CDA-credentialed providers, and vice versa (such as higher reimbursement rates, eligibility for insurance, or access to a toy- and equipment-lending library). The disarray in accreditation is characteristic of the field of family child care. Each community's care has evolved from the grass roots; there has seldom been coordination even at the community level, let alone state or federal coordination.

The disarray in accreditation causes several problems. It hampers efforts to gain acceptance and recognition for accreditation. It hurts individual providers, whose hard-earned credentials are worthless in other communities. Potential sponsors are confused about which of the various approaches they should support; they may not understand the consequences of choosing one over another. Furthermore, groups may find themselves painfully in competition with those who use other approaches, even though they share identical goals. Finally, the potential to develop public policy to support accreditation is diluted and confused.

In contrast, there is only one nationally recognized instrument for accrediting child care centers: NAEYC's Accreditation Criteria for Early Childhood Programs (1984). Efforts to promote center accreditation can be coordinated at a national level; training and technical assistance materials developed by one group can be used by all the others. The gains made in one community or state serve as a model for others. Center accreditation is becoming recognized on a national level, as well as in many communities. Similar coordination would improve recognition for family child care accreditation.

The reality of the field is that there is probably too much real diversity of need to make it possible to come up with one universally accepted form of accreditation, at least in the near future. It might be possible to define reciprocity arrangements among the approaches, similar to the way public school teachers certified in one state are automatically certified in another state, or are given specific additional steps that must be accomplished to earn the new state's certification. For instance, suppose a NAFDC-accredited provider moves to a community where providers who have the CDA credential are entitled to special benefits. The community could decide to grant her eligibility for these benefits by administrating a home visit and the new CDA Professional Preparation test.

One specific barrier to coordination is created by the differing levels of quality recognized by the various instruments. What level on the FDCRS and Louise scales is equivalent to the various accreditations?

If we were to work together to create one nationally recognized accreditation, it should probably include two levels of quality. For example:

Level 1 — offers safe, loving, responsive care; some additional learning materials beyond what would be found in most homes; and basic written policies; and

Level 2 — offers truly professional and developmentally appropriate care and education (in a family child care style, of course); and highly developed written policies.

A second level would define a higher standard of quality, giving providers something more to strive for. Colorado offers advanced accreditation through its Master Provider program (Windflower Enterprises, 1988). Some people argue that a high-level accreditation must be tied to increased compensation for providers.

A consensus-building process will be critical to the success of any single approach (it took four years for the NAEYC center-based accreditation to gain its solid national consensus.) If providers across the country have the opportunity to review and debate the criteria, a strong support base would be established.

A staff member in an agency that accredits providers with an instrument other than NAFDC's made an interesting point. She said that in the long run, NAFDC is the right group to accredit providers. Their accreditation is nationally recognized, and the professional association of an occupation is the most appropriate group to handle accreditation. Doctors and lawyers certify themselves. So should we. This point was supported by another staff member who said that her city was concerned about the liability risk they incurred by accrediting providers, but their instrument includes items they do not want to give up.

Conclusion

The first step in moving toward national coordination of any kind is dialogue. The far-reaching field of family child care needs to come together to take a careful and comprehensive look at quality. We need to share what we have learned in our very different experiences. We need to understand each others' very different situations. We need to explore ways to bring coordination and consensus to the current disarray, while preserving the best of the diversity. Then we will be better able to assesses quality, to recognize and publicize it, and to develop programs and policies that support it.

Part 5. Recommendations

Dialogue Among Family Child Care Professionals

1. Providers and provider associations, trainers and instructors, and researchers need to define further the important characteristics of quality in family child care that are different from center-based quality.

Accreditation

1. Build support for accreditation. It would be highly beneficial to either
   a. come to national consensus about one approach to use for all family child care accreditation; or
   b. devise reciprocity arrangements among the approaches.
2. Offer two levels of accreditation. The first level should be a moderate level, higher in quality than licensing minimums, but reasonably attainable, and based on sound business practice. The second level should be a highly informed level based on principles of child development and early education from a home-based perspective, and on professional business practice. It is this second standard of excellence that would serve to challenge many good providers to seek excellence, as the NAEYC standards have challenged good child care centers to become better.
3. Parents should be informed about the components of quality care and accreditation. Upper-income parents should pay more for high quality care.
4. Assuming that accreditation is one of the most cost-effective ways to improve the quality of family child care, we need dialogue about who should sponsor accreditation support programs. There are several possibilities:

Government. Government at all levels could support the quality of family child care, as occurs in many other countries. The state of Minnesota reimburses providers who have a CDA credential at a higher rate. Head Start's sponsorship of the center-based CDA is an example where our national government supports credentialing of center-based caregivers. National Head Start is gingerly exploring the possibility of expanding its family child care programs. If they do so, it is logical that they will support providers in earning their CDAs.

Dallas offers a highly successful model for how a city, leveraging funds from corporations and foundations, can support accreditation.

Resource and Referral Agencies, Provider Associations, and Colleges. Any group that offers training for providers is a logical sponsor for accreditation. But these groups need public or private funding to supplement providers' tuitions and fees.

Corporations. Several corporations (including Mervyn's, Target Stores, and DuPont) have demonstrated the roles that this sector can play in supporting family child care quality through accreditation.

Parents. Since parents in this country pay most the costs of child care, it is likely that much of the burden of supporting accreditation will fall to them. Upper-income parents will probably seek accredited providers when they learn what accreditation means. This will exacerbate the tendency for rich parents to be able to buy higher-quality care than poor parents can afford. Governmental support is needed to assure that all children have access to good child care.

Research

1. The assessment of quality needs to be expanded to include the "good parent" type of provider.
2. Assessment should include providers' facilitating and extending children's play, not just introducing activities and materials.
3. Assessment should include the quality of children's play and engagement in activities.

Training

1. Specialized family child care training should be developed by colleges, provider associations, and/or resource and referral agencies (ideally working together) in every community. These programs should be taught by people who have experience as providers and knowledge of early education and development and business practices (can be a team).
2. Advanced training relevant to providers should be much more readily available.

Financial Aid

1. Assistance to reduce financial barriers to participation in accreditation and training programs.
2. Define the full cost of family child care, based on an equitable income for providers. Begin the process of shifting the subsidy of child care from providers to employers, upper-income parents, and government for lower-income parents. Family child care should eventually become a viable occupation, not dependent upon perpetual handouts. Then providers will be able to afford to participate in quality-enhancing activities on their own — and they will have financial incentives to do so.

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(The instruments described in this study are shown in bold.)

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